Closure of chest clinics in Ontario

Dr. Raj Narain (*Can Med Assoc J* 1984; 130: 1535–1537) raised a number of interesting questions with regard to whether patients with tuberculosis continued to receive the same level of treatment following the closure of chest clinics throughout Ontario. The Ministry of Health did make some provision to ensure adequate management of tuberculosis and atypical mycobacterial diseases by continuing to provide for the salary of one physician at West Park Hospital, Toronto to help maintain the 58-bed inpatient unit for patients from metropolitan Toronto and surrounding areas with these conditions. The physician also advises colleagues and allied health professionals and assists them in the care of patients with tuberculosis.

West Park Hospital also has two chest clinics per week for new cases and for follow-up of tuberculosis.

The inpatient unit is a valuable resource in the care of patients with tuberculosis, a health problem that still has a relatively high incidence in Ontario.

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Sexually transmitted disease among homosexuals

I would like to comment on Dr. Stephan J. Landis' excellent article "Sexually transmitted disease among homosexuals" (*Can Med Assoc J* 1984; 130: 370–372) and add some information gained from my experience in managing homosexual men.

The pre-AIDS syndromes outlined by Dr. Landis, particularly chronic generalized lymphadenopathy (also known as gay lymphadenopathy syndrome) are now being documented in heterosexual patients with hemophilia and heterosexual Haitians. Heterosexual patients with chronic generalized lymphadenopathy have suffered emotional and psychosocial problems as a result of the stigma attached to the term "pre-AIDS syndrome". This term has therefore been replaced by "AIDS-related complex".

I agree it is imperative to obtain a complete, detailed sexual history to ascertain what risk the patient is at for the various sexually transmitted diseases (STDs) that may occur in sexually active homosexual men. I have found a monograph by Ostrow and colleagues[1] to be an excellent resource book on this subject. The authors discuss thoroughly what information is necessary for a complete sexual history and what diagnostic tests may be indicated.

Presently I screen many homosexual men for STD. I basically follow the routine suggested by Dr. Landis but also include the following measures:

- Routine proctoscopy to facilitate recognition of intra-anal and distal rectal abnormalities (e.g., chancres, herpetic lesions, condylomata acuminata and asymptomatic proctitis) and to obtain swabs for culture of organisms such as *Neisseria gonorrhoeae*, *Chlamydia* and herpesvirus with direct visualization rather than by blindly inserting the swab into the anus.
- Routine examination of stool for ova and parasites on at least three separate occasions. The prevalence of intestinal parasites in homosexual men is remarkably high. In one study 29 (39%) of 75 asymptomatic homosexual men had one or more sexually transmissible anorectal or enteric pathogens.[2] In my continuing screening of sexually active homosexual men, parasites, usually *Entamoeba histolytica* or *Giardia lamblia* or both, have been isolated from more than 50% of the asymptomatic men. Not only are these asymptomatic carriers a hazard to the community at large, but epidemiologic information collected by the United States Centers for Disease Control points to the fact that most patients with AIDS have or have had one or more episodes of intestinal parasite infection (H.W. Jaffe: personal communication, 1983).

All people, regardless of sexual orientation, have the right to quality health care. It is essential that clinicians be aware of the spectrum of diseases that may occur in homosexual men and screen patients appropriately. If a physician chooses not to manage homosexual men he or she should refer these patients to facilities, whether public or private, where they can obtain proper diagnostic and therapeutic management.

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